FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044560

Facility Name: Evergreen Healthcare Center

Address: 10124 S. Kedzie Ave. (Number) Evergreen Park (City) 60805 (Zip Code)

County: Cook

Telephone Number: (708) 636-9200 **Fax #** (708) 636-7375

IDPA ID Number: 364313705001

Date of Initial License for Current Owners: 11/30/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Marvin Fox, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	242	Skilled (SNF)	242	88,330	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	242	TOTALS	242	88,330	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,115	16,428	33,201	70,744	8
9	SNF/PED					9
10	ICF	2,735	728		3,463	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,850	17,156	33,201	74,207	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.01%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/30/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/30/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 242 and days of care provided 28,689

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	433,528	48,708	10,515	492,751		492,751	5,382	498,133			1
2	Food Purchase		391,883		391,883		391,883	(1,419)	390,464			2
3	Housekeeping		26,007	289,884	315,891		315,891		315,891			3
4	Laundry		4,155	185,240	189,395		189,395		189,395			4
5	Heat and Other Utilities			247,030	247,030		247,030	4,390	251,420			5
6	Maintenance	140,409	7,309	216,654	364,372		364,372	(9,127)	355,245			6
7	Other (specify):*											7
8	**TOTAL General Services**	573,937	478,062	949,323	2,001,322		2,001,322	(774)	2,000,548			8
	B. Health Care and Programs											
9	Medical Director			59,333	59,333		59,333		59,333			9
10	Nursing and Medical Records	5,696,348	248,737	577,803	6,522,888		6,522,888	71,786	6,594,674			10
10a	Therapy	162,371	9,460	948	172,779		172,779	2,211	174,990			10a
11	Activities	275,277	23,299	18,643	317,219		317,219		317,219			11
12	Social Services	307,360		1,210	308,570		308,570		308,570			12
13	Nurse Aide Training											13
14	Program Transportation	3,988			3,988		3,988		3,988			14
15	Other (specify):*							9,096	9,096			15
16	**TOTAL Health Care and Programs**	6,445,344	281,496	657,937	7,384,777		7,384,777	83,093	7,467,870			16
	C. General Administration											
17	Administrative	144,748		1,174,325	1,319,073		1,319,073	(636,604)	682,469			17
18	Directors Fees											18
19	Professional Services			262,583	262,583		262,583	(4,083)	258,500			19
20	Dues, Fees, Subscriptions & Promotions			133,222	133,222		133,222	(75,748)	57,474			20
21	Clerical & General Office Expenses	310,780	96,057	395,700	802,537		802,537	(255,903)	546,634			21
22	Employee Benefits & Payroll Taxes			1,336,264	1,336,264		1,336,264		1,336,264			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,870	1,870		1,870	(583)	1,287			24
25	Other Admin. Staff Transportation			56,497	56,497		56,497	(11,638)	44,859			25
26	Insurance-Prop.Liab.Malpractice			411,969	411,969		411,969		411,969			26
27	Other (specify):*							64,508	64,508			27
28	**TOTAL General Administration**	455,528	96,057	3,772,430	4,324,015		4,324,015	(920,051)	3,403,964			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,474,809	855,615	5,379,690	13,710,114		13,710,114	(837,732)	12,872,382			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Evergreen Healthcare Center #0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			116,308	116,308		116,308	212,887	329,195			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,410	1,410		1,410	846,093	847,503			32
33	Real Estate Taxes			480,000	480,000		480,000		480,000			33
34	Rent-Facility & Grounds			1,038,000	1,038,000		1,038,000	(991,331)	46,669			34
35	Rent-Equipment & Vehicles			44,201	44,201		44,201	2,439	46,640			35
36	Other (specify):*											36
37	TOTAL Ownership			1,679,919	1,679,919		1,679,919	70,088	1,750,007			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,889,672	2,280,499	4,170,171		4,170,171	172,760	4,342,931			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,495	132,495		132,495		132,495			42
43	Other (specify):*	60,862		48,059	108,921		108,921	(108,921)				43
44	TOTAL Special Cost Centers	60,862	1,889,672	2,461,053	4,411,587		4,411,587	63,839	4,475,426			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,535,671	2,745,287	9,520,662	19,801,620		19,801,620	(703,805)	19,097,815			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(513)	02		4
5	Telephone, TV & Radio in Resident Rooms	(158)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(239,204)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(906)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(19,829)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(235,980)	21		24
25	Fund Raising, Advertising and Promotional	(39,974)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(233,181)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (769,745)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	65,940		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 65,940		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (703,805)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Evergreen Healthcare Center

ID# 0044560

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Accounting Fees - Building Company	$ (1,863)	19	1
2	Telephone Revenue	(9)	21	2
3	Interest Income	(5,200)	32	3
4	Miscellaneous Income	(25)	21	4
5	Non-allowable Travel/Entertainment	(10,422)	25	5
6	Advertising	(9,629)	20	6
7	Capitalized Repairs & Maintenance	(19,188)	06	7
8	ICLTC-COPE	(3,664)	20	8
9	Non-allowable Recruiting Expense	(62,455)	20	9
10	Non-allowable Seminar	(583)	24	10
11	Marketing Salary	(60,862)	43	11
12	Marketing Expense	(8,085)	43	12
13	Prior Period Legal Fees	(4,083)	19	13
14	Non-allowable Marketing Travel	(1,216)	25	14
15	Building Company Licenses & Fees	(200)	20	15
16	Building Company Amortization	(45,637)	31	16
17	Meals & Entertainment	(60)	21	17
18				18
19				19
20				20
21				21
22				22
23				23
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98				98
99				99
100				100
101	**Total**	(233,181)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evergreen Healthcare Center # 0044560 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			5,382									5,382	1
2	Food Purchase	(1,419)											(1,419)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			4,390									4,390	5
6	Maintenance	(19,346)		10,219									(9,127)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(20,765)		19,991									(774)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			71,786									71,786	10
10a	Therapy				2,211								2,211	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			9,096									9,096	15
16	**TOTAL Health Care and Programs**			80,882	2,211								83,093	16
	C. General Administration													
17	Administrative			(636,604)									(636,604)	17
18	Directors Fees													18
19	Professional Services	(5,946)	1,863										(4,083)	19
20	Fees, Subscriptions & Promotions	(75,948)	200										(75,748)	20
21	Clerical & General Office Expenses	(255,903)											(255,903)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(583)											(583)	24
25	Other Admin. Staff Transportation	(11,638)											(11,638)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			64,508									64,508	27
28	**TOTAL General Administration**	(350,018)	2,063	(572,096)									(920,051)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(370,783)	2,063	(471,223)	2,211								(837,732)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evergreen Healthcare Center # 0044560 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(239,204)	429,108	22,983									212,887	30
31	Amortization of Pre-Op. & Org.	(45,637)	45,637											31
32	Interest	(5,200)	845,535	5,758									846,093	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,038,000)	46,669									(991,331)	34
35	Rent-Equipment & Vehicles			2,439									2,439	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(290,041)	282,280	77,849									70,088	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				172,760								172,760	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(108,921)											(108,921)	43
44	**TOTAL Special Cost Centers**	(108,921)			172,760								63,839	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(769,745)	284,343	(393,374)	174,971								(703,805)	45

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Evergreen Healthcare Realty	100%	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,038,000	Evergreen Healthcare Realty, LLC		$	$ (1,038,000)	1
2	V	32	Interest Income	9,252	Evergreen Healthcare Realty, LLC			(9,252)	2
3	V	32	Interest Expense-Mortgage		Evergreen Healthcare Realty, LLC		854,787	854,787	3
4	V	19	Accounting Fees		Evergreen Healthcare Realty, LLC		1,863	1,863	4
5	V	20	Licenses And Fees		Evergreen Healthcare Realty, LLC		200	200	5
6	V	30	Depreciation		Evergreen Healthcare Realty, LLC		228,128	228,128	6
7	V	31	Amortization		Evergreen Healthcare Realty, LLC		45,637	45,637	7
8	V	30	Depreciation		Evergreen Healthcare Realty, LLC		200,980	200,980	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,047,252			$ 1,331,595	$ * 284,343	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 1,174,325	Boulevard Healthcare Management, LLC	100.00%	$	$ (1,174,325)	15
16	V	5	Utilities		Boulevard Healthcare Management, LLC	100.00%	4,390	4,390	16
17	V	10	Nursing & Rehabilitation		Boulevard Healthcare Management, LLC	100.00%	71,786	71,786	17
18	V	15	Payroll Taxes,Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	9,096	9,096	18
19	V	1	Dietary Expenses		Boulevard Healthcare Management, LLC	100.00%	5,382	5,382	19
20	V	17	Administrative & General		Boulevard Healthcare Management, LLC	100.00%	537,721	537,721	20
21	V	6	Maint. & Minor Equipment		Boulevard Healthcare Management, LLC	100.00%	10,219	10,219	21
22	V	27	Payroll Taxes,Fringes, Staff Dev.		Boulevard Healthcare Management, LLC	100.00%	64,508	64,508	22
23	V	30	Depreciation		Boulevard Healthcare Management, LLC	100.00%	22,983	22,983	23
24	V	34	Lease & Rent - Building		Boulevard Healthcare Management, LLC	100.00%	46,669	46,669	24
25	V	35	Lease & Rent - Equipment		Boulevard Healthcare Management, LLC	100.00%	2,439	2,439	25
26	V	32	Interest Expense		Boulevard Healthcare Management, LLC	100.00%	5,758	5,758	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,174,325			$ 780,951	$ * (393,374)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 28,602	ADVANCED THERAPY & REHAB, LLC	100.00%	$ 30,813	$ 2,211	15
16	V	39	ANCILLARY REHAB	2,234,929	ADVANCED THERAPY & REHAB, LLC	100.00%	2,407,689	172,760	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,263,531			$ 2,438,502	$ * 174,971	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brian Cloch	Dir Of Operations	Management	2.90%	See Attached	2.32	9.28%	Alloc Salary	$ 19,813	17-07	1
2	Fred Benjamin	Owner	Administrative	1.45%	See Attached	8.34	15.17%	Alloc Salary	47,682	17-07	2
3	Beth Benoudiz	CFO	Administrative	0.26%	See Attached	0.79	4.75%	Alloc Salary	21,007	17-07	3
4	Sherri Noon	Administrative	Administrative	0.06%	See Attached	9.27	18.54%	Alloc Salary	19,479	17-07	4
5	Charles Ross	Administrative	Administrative	0.06%	See Attached	6.95	18.54%	Alloc Salary	24,328	17-07	5
6	Barbara Larimore	Bookkeeping	Administrative	0.09%	See Attached	4.93	13.15%	Alloc Salary	6,830	17-07	6
7	Steve Van Camp	Administrative	Administrative	0.29%	See Attached	9.27	18.54%	Alloc Salary	37,060	17-07	7
8	Jeff Elowe	Administrative	Administrative	10.60%	See Attached	3.71	9.28%	Alloc Salary	37,060	17-07	8
9	Melissa Deal (Clarke)	Nurse Consultant	Nursing	0.12%	See Attached	5.68	22.72%	Alloc Salary	20,144	10-07	9
10	Denise Norman	Therapy Mgmt.	Management	0.15%	See Attached	0.79	4.75%	Alloc Salary	29,843	39-07	10
11	Mike Filippo	Administrative	Administrative	0.29%	See Attached	2.78	16.68%	Alloc Salary	25,291	17-07	11
12											12
13								TOTAL	$ 288,537		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Boulevard Healthcare Management, LLC
Street Address: 8950 Gross Point Road, Suite 600
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	5	Utilities	Patient Days/Direct	326,889	6	19,339		Direct	4,390	2
3	10	Nursing & Rehabilitation	Patient Days/Direct	326,889	6	312,818	311,818	Direct	71,786	3
4	15	Payroll Taxes,Fringes, Staff Dev.	Patient Days/Direct	326,889	6	40,068		Direct	9,096	4
5	1	Dietary Expenses	Patient Days/Direct	326,889	6	54,630	54,630	Direct	5,382	5
6	17	Administrative & General	Patient Days/Direct	326,889	6	2,957,288	2,303,745	Direct	537,721	6
7	6	Maint. & Minor Equipment	Patient Days/Direct	326,889	6	45,017	38,963	Direct	10,219	7
8	27	Payroll Taxes,Fringes, Staff Dev.	Patient Days/Direct	326,889	6	323,551		Direct	64,508	8
9	30	Depreciation	Patient Days/Direct	326,889	6	101,243		Direct	22,983	9
10	34	Lease & Rent - Building	Patient Days/Direct	326,889	6	205,579		Direct	46,669	10
11	35	Lease & Rent - Equipment	Patient Days/Direct	326,889	6	10,745		Direct	2,439	11
12	32	Interest Expense	Patient Days/Direct	326,889	6	25,363		Direct	5,758	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,095,642	$ 2,709,156		$ 780,951	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						30,813	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						2,407,689	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,438,502	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage			$	$ 12,397,868			$ 854,787	1
2	DeLage Landen		X	Equipment Financing							733	2
3	Hill-Rom		X	Equipment Financing							404	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Note Payable-Other		X	Working Capital				4,221				6
7	Allocated From Boulevard HC										5,758	7
8	See Supplemental Schedule										274	8
9	TOTAL Facility Related						$	$ 12,402,089			$ 861,956	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(5,200)	11
12												12
13	See Supplemental Schedule										(9,252)	13
14	TOTAL Non-Facility Related						$	$			$ (14,452)	14
15	TOTALS (line 9+line14)						$	$ 12,402,089			$ 847,504	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Universal RE		X	Insurance Financing			$	$			$ 274	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										274	14
	B. Non-Facility Related*											
15	Allocated Evergreen HC Realty						$	$			$ (9,252)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(9,252)	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Evergreen Healthcare Center # 0044560 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1,417,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,417,500)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	1,897,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	480,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

Property Purchased From Not For Profit. Tax Bill Not Yet Received.

Accrual Based On Real Estate Tax Estimate.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evergreen Healthcare Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044560

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evergreen Healthcare Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044560

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,212 B. General Construction Type: Exterior Brick Frame Basement Foundation Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 1,627,500	1
2					2
3	TOTALS			$ 1,627,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	3,440		20	172	172	516	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		7,959,539	394,620		213,145	(181,475)	870,095	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		3,983	797		797		1,266	68
69	Financial Statement Depreciation			8,156			(8,156)		69
70	TOTAL (lines 4 thru 69)		$ 7,966,962	$ 403,573		$ 214,114	$ (189,459)	$ 871,877	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,966,962	$ 403,573		$ 214,114	$ (189,459)	$ 871,877	1
2	Sewage Pump	2000	5,305		20	265	265	796	2
3	Office Carpeting	2000	1,834		20	92	92	275	3
4	Sewer Pump	2000	5,305		20	265	265	796	4
5	Plumbing	2000	837		20	42	42	126	5
6	Roof Repair	2000	590		20	30	30	89	6
7	Kitchen Repipe	2000	1,307		20	65	65	196	7
8	Roof Ventilator	2000	575		20	29	29	87	8
9	Repair Roof Top	2000	1,075		20	54	54	162	9
10	Sprinkler Repair	2000	750		20	38	38	113	10
11	Boiler Repair	2000	1,072		20	54	54	161	11
12	Concrete Work	2001	6,000		20	300	300	775	12
13	Carpet	2001	2,100		20	105	105	254	13
14	Water Heater	2001	5,456		20	273	273	614	14
15	Compressor Repair	2001	7,229		20	361	361	964	15
16	Conduits	2001	3,550		20	178	178	489	16
17	Filters	2001	535		20	27	27	74	17
18	Ventillation Dompers	2001	900		20	45	45	124	18
19	Concrete	2001	2,200		20	110	110	303	19
20	Freezer Piping	2001	2,460		20	123	123	349	20
21	Filters	2001	545		20	27	27	71	21
22	Filters	2001	840		20	42	42	105	22
23	Refrigeration Repair	2001	574		20	29	29	84	23
24	Hydroguard	2001	613		20	31	31	66	24
25	Hydraulic Gas Valve	2001	1,050		20	53	53	109	25
26	Wallpaper	2001	941		20	47	47	129	26
27	Cubicle Curtains	2002	5,670		20	567	567	1,040	27
28	Replacement Blinds	2002	2,593		20	259	259	454	28
29	Nurse Call/ Pocket Page System	2002	1,280		20	128	128	224	29
30	Tv Hook Ups	2002	7,500		20	750	750	1,250	30
31	Transmitter Bands	2002	587		20	59	59	88	31
32	Cabling Facility	2002	15,002		20	1,500	1,500	2,875	32
33	Replace Frequency Drive	2002	2,900		20	290	290	508	33
34	TOTAL (lines 1 thru 33)		$ 8,056,137	$ 403,573		$ 220,352	$ (183,221)	$ 885,627	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,056,137	$ 403,573		$ 220,352	$ (183,221)	$ 885,627	1
2	Security System On Exits	2002	2,387		20	239	239	398	2
3	Security System On Exits	2002			20				3
4	Repair Fire Sprinkler	2002	2,390		20	239	239	398	4
5	Replace Condenser	2002	1,050		20	105	105	166	5
6	Convert Duplex To Quads	2002	28,300		20	2,830	2,830	4,481	6
7	Replace Damper Motor	2002	1,058		20	106	106	141	7
8	Wall & Chimney Work	2002	4,240		20	424	424	565	8
9	Replace Damper Motor	2002	1,013		20	101	101	127	9
10	Heat Exchanger	2002	797		20	80	80	93	10
11	Heat Exchanger	2002	525		20	53	53	61	11
12	Heat Exchanger	2002	104		20	10	10	12	12
13	Heat Exchanger	2002	393		20	39	39	43	13
14	Heat Exchanger	2002	3,475		20	348	348	376	14
15	Heat Exchanger	2002	1,775		20	178	178	192	15
16	Heat Exchanger	2002	600		20	60	60	65	16
17	Replace Compressors	2002	4,330		20	433	433	686	17
18	Locks	2002	513		20	45	45	71	18
19	Exhaust Fan	2002	564		20	56	56	94	19
20	Air Temp Sensor	2002	1,002		20	100	100	167	20
21	Counter Top	2002	575		20	58	58	91	21
22	Paint & Wallpaper	2002	550		20	55	55	87	22
23	Repairs	2002	880		20	88	88	132	23
24	Black Box	2002	635		20	64	64	95	24
25	Vent Repair	2002	1,450		20	145	145	205	25
26	Cord For Security Tv	2002	597		20	60	60	80	26
27	Mini-Blinds	2002	543		20	54	54	104	27
28	Floor Patch	2002	500		20	50	50	83	28
29	Carpeting	2003	1,755		20	176	176	176	29
30	Centrifugal Vent	2003	676		20	56	56	56	30
31	Telephone Equipment	2003	129,400		20	8,627	8,627	8,627	31
32	Vertical Blinds	2003	630		20	53	53	53	32
33	Counter Top	2003	1,067		20	62	62	62	33
34	TOTAL (lines 1 thru 33)		$ 8,249,911	$ 403,573		$ 235,346	$ (168,227)	$ 903,614	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,249,911	$ 403,573		$ 235,346	$ (168,227)	$ 903,614	1
2	Tree & Shrubs	2003	19,230		20	2,244	2,244	2,244	2
3	Air Conditioner	2003	2,132		20	178	178	178	3
4	Replace Pipes	2003	968		20	89	89	89	4
5	Data Drop Lines	2003	2,626		20	219	219	219	5
6	Duct Work Hvac	2003	1,717		20	143	143	143	6
7	Hvac	2003	1,608		20	134	134	134	7
8	Replace Doors	2003	1,996		20	133	133	133	8
9	Replace Doors	2003	2,982		20	199	199	199	9
10	Hvac	2003	1,199		20	90	90	90	10
11	Hvac	2003	1,327		20	100	100	100	11
12	Hvac	2003	3,915		20	261	261	261	12
13	Hvac	2003	3,350		20	223	223	223	13
14	Hvac	2003	1,183		20	79	79	79	14
15	Replace Doors	2003	3,573		20	208	208	208	15
16	Hvac	2003	3,550		20	207	207	207	16
17	Hvac	2003	834		20	49	49	49	17
18	Hvac	2003	669		20	33	33	33	18
19	Hvac	2003	710		20	36	36	36	19
20	Electrical	2003	750		20	31	31	31	20
21	Install Counter	2003	853		20	36	36	36	21
22	Water Heater Piping	2003	5,950		20	248	248	248	22
23	Hvac	2003	3,475		20	145	145	145	23
24	Oak Door	2003	1,560		20	39	39	39	24
25	Oak Doors	2003	3,040		20	76	76	76	25
26	Computer Datalines	2003	17,083		20	813	813	813	26
27	Electric Recepticles	2003	750		20	31	31	31	27
28	Computer Data Lines	2003	2,746		20	69	69	69	28
29	Nurse Call System	2003	1,424		20	142	142	142	29
30	Roof Repair	2003	2,709		20	248	248	248	30
31	Fire System Repair	2003	697		20	52	52	52	31
32	Roof Repair	2003	5,500		20	321	321	321	32
33	Storeroom Locks	2003	650		20	38	38	38	33
34	TOTAL (lines 1 thru 33)		$ 8,350,667	$ 403,573		$ 242,260	$ (161,313)	$ 910,528	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,350,667	$ 403,573		$ 242,260	$ (161,313)	$ 910,528	1
2	Phone System Repair	2003	1,394		20	70	70	70	2
3	Electronic Locks	2003	508		20	25	25	25	3
4	Roof Repair	2003	742		20	25	25	25	4
5	Fire System Repair	2003	700		20	41	41	41	5
6	Phone System Repair	2003	1,581		20	13	13	13	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,355,592	$ 403,573		$ 242,434	$ (161,139)	$ 910,702	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	242		1999		$ 7,052,500	$ 381,813		$ 201,500	$ (180,313)	$ 822,792	4
5			1999		303,742			8,678	8,678	35,435	5
6			2000		103,836			2,967	2,967	11,868	6
7											7
8											8
	Improvement Type**										
9	Duct Work			2000	90,000						9
10	Masonry Restorater			2000	131,234						10
11	Permit Fees			2000	5,165						11
12	Parking Lot			2000	108,000						12
13	Parking Lot-Engineer			2000	2,500						13
14	Architect Fees			2000	11,619						14
15	Survey Fees			2000	2,000						15
16	General Contract Fees			2000	25,356						16
17	General Contract Fees			2001	3,538						17
18	Architect Fees			2001	3,097						18
19	Landscaping			2001	27,435						19
20	Parking Lot			2001	50,000						20
21	Curb Replacement			2001	2,200						21
22	Roof Repair			2001	2,200						22
23	Bathroom			2001	2,250						23
24	Tile Work			2001	500						24
25	Kitchen Work			2001	3,900						25
26	Vending Area Work			2001	1,900						26
27	Kitchen Work			2001	1,084						27
28	A/C Units			2001	4,884						28
29	Sheet Metal System			2001	9,540						29
30	Architect Fees			2001	4,579						30
31	Architect Fees			2002	6,480						31
32											32
33											33
34											34
35											35
36						12,807			(12,807)		36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,959,539	$ 394,620		$ 213,145	$ (181,475)	$ 870,095	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From Boulevard Healthcare			2002	3,983	797	20	797		1,266	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,983	$ 797		$ 797	$	$ 1,266	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,657,105	$ 102,165	$ 57,683	$ (44,482)	10	$ 132,815	71
72	Current Year Purchases	281,920	62,660	29,077	(33,583)	10	29,077	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,939,025	$ 164,825	$ 86,760	$ (78,065)		$ 161,892	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,922,117	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 568,398	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 329,194	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (239,204)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,072,594	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated From Boulevard HC				46,669			5
6								6
7	TOTAL				$ 46,669 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 46,639 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 326,998	$		$ 326,998	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			104,364			104,364	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,849,137			1,849,137	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				959,484		959,484	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						930,188		930,188	13
14	TOTAL			$		$ 2,280,499	$ 1,889,672		$ 4,170,171	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center **#** 0044560 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,198,038	$ 1,236,769	1
2	Cash-Patient Deposits	23,127	23,127	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,340,972	2,340,972	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		473,361	5
6	Prepaid Insurance	8,416	8,416	6
7	Other Prepaid Expenses	17,934	17,934	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	1,023,584	42,989	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,612,071	$ 4,143,568	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,627,500	13
14	Buildings, at Historical Cost		7,052,500	14
15	Leasehold Improvements, at Historical Cost	144,751	644,211	15
16	Equipment, at Historical Cost	808,169	2,967,372	16
17	Accumulated Depreciation (book methods)	(234,501)	(2,944,100)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	4,133	517,958	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 722,552	$ 9,865,441	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,334,623	$ 14,009,009	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 742,098	$ 742,098	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,379	30,379	28
29	Short-Term Notes Payable	4,221	4,221	29
30	Accrued Salaries Payable	428,415	428,415	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,039	19,039	31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,897,500	1,897,500	32
33	Accrued Interest Payable		77,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	350	350	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	292,471	292,471	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,414,473	$ 3,491,815	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,397,868	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,397,868	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,414,473	$ 15,889,683	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,920,150	$ (1,880,674)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,334,623	$ 14,009,009	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,045,322	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,045,322	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(125,172)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (125,172)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,920,150	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 19,900,849	1
2	Discounts and Allowances for all Levels	(12,756,551)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,144,298	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,895,331	6
7	Oxygen	40,856	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,936,187	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,581	13
14	Non-Patient Meals	513	14
15	Telephone, Television and Radio	9	15
16	Rental of Facility Space		16
17	Sale of Drugs	924,380	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	256,995	19
20	Radiology and X-Ray	49,094	20
21	Other Medical Services	349,160	21
22	Laundry	1,855	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,588,587	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,200	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,200	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,176	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,176	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,676,448	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,001,322	31
32	Health Care	7,384,777	32
33	General Administration	4,324,015	33
	B. Capital Expense		
34	Ownership	1,679,919	34
	C. Ancillary Expense		
35	Special Cost Centers	4,279,092	35
36	Provider Participation Fee	132,495	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,801,620	40
41	**Income before Income Taxes (line 30 minus line 40)****	(125,172)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (125,172)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,210	1,309	$ 50,335	$ 38.45	1
2	Assistant Director of Nursing	2,806	3,004	93,714	31.20	2
3	Registered Nurses	77,835	84,091	2,177,103	25.89	3
4	Licensed Practical Nurses	51,981	63,726	1,426,824	22.39	4
5	Nurse Aides & Orderlies	161,437	182,411	1,822,762	9.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,971	10,500	162,371	15.46	8
9	Activity Director	7,504	8,769	114,830	13.09	9
10	Activity Assistants	14,888	16,970	160,447	9.45	10
11	Social Service Workers	15,928	17,199	307,360	17.87	11
12	Dietician	4,388	5,024	78,598	15.64	12
13	Food Service Supervisor	2,301	3,342	41,215	12.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,136	33,481	313,715	9.37	15
16	Dishwashers					16
17	Maintenance Workers	7,489	8,282	140,409	16.95	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,362	1,497	80,206	53.58	20
21	Assistant Administrator	1,976	2,092	64,542	30.85	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,744	22,249	310,780	13.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,459	8,959	125,610	14.02	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,567	2,636	64,849	24.60	33
34	TOTAL (lines 1 - 33)	418,982	475,541	$ 7,535,670 *	$ 15.85	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	348	$ 10,515	01-03	35
36	Medical Director	Monthly	59,333	09-03	36
37	Medical Records Consultant	100	4,286	10-03	37
38	Nurse Consultant	Monthly	78,300	10-03	38
39	Pharmacist Consultant	Monthly	20,328	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	18	948	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	532	18,643	11-03	44
45	Social Service Consultant	24	1,210	12-03	45
46	Other(specify)				46
47	Alzheimers Consultant	Monthly	8,037		47
48	Wound Care Consultant	918	55,109	10-03	48
49	TOTAL (lines 35 - 48)	1,940	$ 256,709		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,486	$ 277,000	10-03	50
51	Licensed Practical Nurses	3,897	124,712	10-03	51
52	Nurse Aides	557	10,031	10-03	52
53	TOTAL (lines 50 - 52)	11,940	$ 411,743		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Martin Bukacek 01/01/03-09/06/03	Administrator	0%	$ 79,049
Michael Stout	Assist. Admin.	0%	65,699
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,748

B. Administrative - Other

Description	Amount
Management Fee-Boulevard Healthcare Mgmt.	$ 1,174,325
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,174,325
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost,Ruttenberg&Rothblatt	Accounting	$ 10,022
Personnel Planners	Unemployment Conslt.	4,925
HDSI	Data Processing	3,343
Trenaman Consulting Group	Accounts Receivable	500
Sachnoff & Weaver	Legal	58,537
Tobin Meritt & Associates	Administrative	91,796
Documentations Solutions, Inc	General Conslt.	4,630
Linda Lipinski	Human Resources	1,875
Various	Legal	57,364
Seyfarth & Shaw	Legal	568
ADP	Data Processing	5,163
See Supplemetal Schedule		23,862
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 262,585

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 202,694
Unemployment Compensation Insurance	82,569
FICA Taxes	549,251
Employee Health Insurance	384,350
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Disability Insurance	37,073
Employee Life Insurance	11,936
Employee Dental/Vision	4,726
401K Expense	19,916
Other Employee Benefits	43,749
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,336,264

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	34,037
Health Care Worker Background Check	
(Indicate # of checks performed 26)	423
Licenses	9,052
ICLTC Dues	10,130
Dues & Subscriptions	3,571
Recruiting Expense	261
Advertising	9,629
Less: Public Relations Expense	( )
Non-allowable advertising	(9,629)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,474

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,287
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,287

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Evergreen Healthcare Center # 0044560 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evergreen Healthcare Center # 0044560 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC $13,794**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **435** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **132,495**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Of Line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.